MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 11331

Reg. Diat. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs.

Hospital, Institution, or street address where death occurred: Imperial Hotel apts.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Imperial Hotel apts.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Elizabeth Pace Sarmon Bell

3. (b) Social Security Number: —

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: (Late) Harrison Maize Bell

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 11, 1861

8. AGE: Years: 86 Months: 3 Days: 17 If less than one day: hrs. min.

9. Birthplace: Cheshire, England
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: home

FATHER
12. Name: Hugh Sarmon
13. Birthplace: England

MOTHER
14. Maiden name: Harriett Pace
15. Birthplace: Liverpool, England

16. Informant: Miss Doris T. Bell (daughter)

Address: Chestertown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1947 (month) (day) (year)

Cemetery or crematory: St. Paul

Location: Near - Fairlee, Kent Co. Md.

18. Funeral director: Marvin V. Williams

Address: Chestertown, Maryland

19. Dec. 30 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1947 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1943 to Dec 28 1947 and that I last saw him alive on Dec 27 1947

Immediate cause of death: Myocardosis

Due to: Arteriosclerosis

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Fonts M.D.

M. D. or other

Address: Westbrook Md. Date signed: Dec 29 1947

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

928

11332

CERTIFICATE OF DEATH

Reg. Dist. No. 280

1. PLACE OF DEATH:

County: Kent

City or town: Rural Chesterville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Rural Chesterville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie E. Cooper

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or ~~wife~~ William B.

6.(c) If alive, give age 90 years

7. Birth date of deceased (mo., day, yr.) October 3, 1868

8. AGE: Years 79 Months 2 Days If less than one day hrs. min.

9. Birthplace Berks Co. Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William B. Smith

13. Birthplace Pa.

MOTHER 14. Maiden name Mary Turner

15. Birthplace Pa.

16. Informant William B. Cooper

Address Rural Chesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 8 1947 (month) (day) (year)

Cemetery or crematory Fernwood

Location Lansdowne, Pa.

18. Funeral director Edward Fellows

Address Wellington, Md.

19. Dec. 6 1947 (Date rec'd by registrar) Edward Fellows Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1947, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1947, to Dec. 4 1947 and that I last saw him alive on Dec. 8 1947

Immediate cause of death	DURATION
Mitral Stenosis	2 years
Due to Auric. Fibrillation	1940
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Merritt Bair M. D. or other

Address Wellington Md. Date signed Dec. 6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11333

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: Pomona

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pomona
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Amanda Frances Derry

3. (b) Social Security Number

4. Sex: fem

5. Color or race: col

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Wm. Derry

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): March 5 1878

8. AGE: Years: 69 Months: 5 Days: 29 If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Chestertown Md

10. Usual occupation: House

11. Industry or business: own home

FATHER

12. Name: Wm Henry Johnson

13. Birthplace: Virginia

MOTHER

14. Maiden name: Amanda A. Carey

15. Birthplace: Chestertown, Md.

16. Informant: Thomas Johnson

Address: Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7 1947 (month) (day) (year)

Cemetery or crematory: Crackers Neck Cemetery

Location: Pomona, Kent Co, Md.

18. Funeral director: Asbury Henry

Address: Chestertown, Md R.F.D. # 2

19. Dec. 5 1947 (Date rec'd by registrar) Clara L. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 1947, to Dec 4 1947 and that I last saw h... alive on Dec 1 1947

Immediate cause of death: chron. endo-myocarditis decompensation

Due to: Hypertension

Due to: Paralysis of L side.

Other conditions

(Include pregnancy within 3 months of death)

DURATION
5½ years

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 12/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

11334

CERTIFICATE OF DEATH

Reg. Diat. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Kent & Queen Ann Hosp.

How long in hospital or institution? 1-day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 Queen St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Wesley Derry

3.(b) Social Security Number: —

4. Sex: Male

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 13 1873

8. AGE: Years 74 | Months 6 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace: Kent Co. Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: William Derry
13. Birthplace: Kent Co. Maryland

MOTHER
14. Maiden name: Jane Louisa Hanann
15. Birthplace: unknown

16. Informant: Mr. George H. Ringgold
Address: 406 Calvert St. Chestertown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Pomona

Location: Pomona, Kent Co. Maryland

18. Funeral director: Marvin V. Williams
Address: Chestertown, Maryland

19. Dec. 30, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1947 to Dec 28 1947 and that I last saw him alive on Dec. 28 1947

Immediate cause of death	DURATION
Uremia	
Due to 1.) Acute urinary retention	
2.) Urinary tract infection	
Due to	
Other conditions: Carcinoma of prostate	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. R. Coppola, M.D. (M. D. or other)

Address: Chestertown, Maryland Date signed: 12-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

113353

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Mifflin

City or town: Lewistown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thora Harriett DILLREE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Frank Dillree

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1878

8. AGE:

Years	Months	Days	If less than one day
69	10	14	..... hrs. ..... min.

9. Birthplace: Oslo - NORWAY
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Hendrickson
13. Birthplace: NORWAY

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. Barbara Slabach
Address: Rock Hall, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 15 1947
(month) (day) (year)

Cemetery or crematory: Lakewood Cemetery

Location: Minneapolis-Hennepin County, Minnesota

16. Funeral director: J. Willis Wells
Address: Chestertown, Maryland

19. Dec. 12, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar 202

Edward Burger 203

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11th. 19 47, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend 19 ..... to 19 ..... and that I last saw h... alive on 19 ..... Did not investigated death signed Certificate as deputy Med. Examiner Kent County Maryland

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of

Where did injury occur? none
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) none

Means of injury none Injured at work?

23. SIGNATURE: Dock Hines M.D.
Deputy Medical Examiner
Kent County Maryland
M. D. or other

Address: Chestertown, Maryland Date signed 12/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11336

93d

Reg. Diat. No. 203

1. PLACE OF DEATH: Kent

County

City or town: Rock Hall R.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall R.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME John F. Greenwood

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widdower

6.(b) Name of husband or wife: Dont Know

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 81 Months: Days: If less than one day hrs. min.

9. Birthplace: Kent County Md. (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Blackismithing

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. E. Perry

Address: Rock Hall R.D. Kent Co Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof Dec 6-47 (month) (day) (year)

Cemetery or crematory: St. Paul

Location: Near Fairlee Md

18. Funeral director: Edgar L Lane

Address: Church Hill Md

19. Dec. 6. 1947 S. Elwood Burgess Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5. 1947 19 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 last seen alive 19

Did not attend investigated death signed certificate as Deputy Med. Exam.

Immediate cause of death: Myocarditis Atefio Sclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? None
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: None Injured at work?

23. Signature: Deputy Med. Exam. David Stone M.D.

Address: Chestertown Md. Date signed: Dec 6. 47

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11337

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Still Pond Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Still Pond Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME John Thomas Holley

3.(b) Social Security Number —

4. Sex: Male

5. Color or race: C

6.(a) Single, married, widowed, or divorced: Widowed.

6.(b) Name of husband or wife: Ida Holley

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 9 1879

8. AGE: Years 68 Months 5 Days 3 If less than one day ____ hrs. ____ min.

9. Birthplace: Centreville Md (Town, county, and state)

10. Usual occupation: Farm Work

11. Industry or business: Farm

MOTHER FATHER

12. Name: Unknown

13. Birthplace: Queens Co Md

MOTHER

14. Maiden name: Unknown

15. Birthplace: Queen Anns Co

16. Informant: Henry R Ford

Address: Still Pond Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 14 1947 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Still Pond, Md.

18. Funeral director: B N Fellows

Address: Still Pond, Md

19. 12-14 1947 J H Clark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 1947 to Dec 12 1947 and that I last saw him alive on Dec 11 1947

Immediate cause of death: Apoplexy DURATION Unknown

Due to: Arteria Sclerosis DURATION Yrs

Due to: ____ DURATION ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. ____

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of ____

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury None Injured at work? ____

23. SIGNATURE: Frank Jones MD
Dr. Jones Queen Anne Md

Address: Hospital Tom Md Date signed Dec 12 1947 M. D. or other

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11338

107

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, Institution, or street address where death occurred: Kent & Queen Ann Hospital

How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cannon St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME William Joiner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Joiner

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): april 22 1869

8. AGE:

Years	Months	Days	If less than one day
78	8	8	____ hrs. ____ min.

9. Birthplace: Sound View Kent Co. Maryland (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: retired

FATHER

12. Name: Charles W. Joiner

13. Birthplace: Kent Co. Maryland

MOTHER

14. Maiden name: Hattie Lee

15. Birthplace: Kent Co.

16. Informant: Mr. Charles W. Joiner

Address: Lynch, Kent Co. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 1, 1948 (month) (day) (year)

Cemetery or ~~crematory~~: Chester

Location: Chestertown, Kent Co. Md.

18. Funeral director: Marvin V. Wolfhain

Address: Chestertown, Md.

19. Jan. 1, 1948 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1947, to Dec. 30 1947 and that I last saw him alive on Dec. 30 1947

Immediate cause of death: Pneumonia, bronchial (1/26/48 abc)

DURATION

Due to:

Due to:

Other conditions: possible cerebrovascular lesion without localizing signs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. R. Coppola M.D. M. D. or other

Address: Chestertown, Md. Date signed: 12-31-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

11339

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo

Hospital, institution, or street address where death occurred: Melvin Home.

How long in hospital or institution? 6 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Still Pond Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Tilden Jones.

3.(b) Social Security Number 166-07-6846.

4. Sex: Male.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed.

6.(b) Name of husband or wife: Mabel Jones

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 26 1876

8. AGE: Years 71 Months 4 Days 19 If less than one day ... hrs. ... min.

9. Birthplace: Kennedyville Md
(Town, county, and state)

10. Usual occupation: Labor Boss

11. Industry or business: Baldwin Co

FATHER 12. Name: George H Jones

13. Birthplace: Maryland

MOTHER 14. Maiden name: Anna Howard

15. Birthplace: Maryland.

16. Informant: Sarah Stilman

Address: 35 Brandon Rd Upper Darby

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16 1947 (month) (day) (year)

Cemetery or crematory: Schuylkill

Location: near Kennedyville Md

18. Funeral director: B R Fellows

Address: Still Pond Md

19. 12-16 1947 (Date rec'd by registrar) J M Leach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1947 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Dec 16 1947 and that I last saw him alive on Dec 13 1947.

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to: Chronic Myocarditis	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: J M Leach M. D. or other

Address: Rockville Md Date signed: 12/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

11341

1572

1. PLACE OF DEATH

County: Kent — Registration Dist. No. 200

Village or City: Millington — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Bertha Jane Sloyed — If U. S. Veteran, specify WAR ____

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) May 1, 1947

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	7		

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ____

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ____

10. Date deceased last worked at this occupation (month and year) ____ — 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) Near Townsend, Del (State or country)

FATHER

13. NAME Henry Sloyed

14. BIRTHPLACE (city or town) Maryland (State or country)

MOTHER

15. MAIDEN NAME Avis Lowell

16. BIRTHPLACE (city or town) Delaware (State or country)

17. INFORMANT Avis Sloyed (Address) Townsend, Del

18. BURIAL, CREMATION, OR REMOVAL Place Delaneys Date 12/2/47, 19____

19. UNDERTAKER D. Lester Daniels (Address) MIDDLETOWN, DEL

20. FILED Dec. 3, 1947 Edward Fellows Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec. (Month) 1st (Day) 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____

I last saw her alive on 12/1/47, 19____; death is said to have occurred on the date stated above, at 12 midnight

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Congenital heart Disease	

Other Contributory Causes of Importance:

Name of operation — Date of ____

What test confirmed diagnosis? — Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) H. H. Hamilton M. D.

(Address) Millington Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1097B

11341

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Kent & Queen Ann Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Worton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Allen LOLLER

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7, 1943

8. AGE:

Years	Months	Days	If less than one day
4	2	15	hrs. min.

9. Birthplace: Chestertown Kent Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: William Edward Loller
13. Birthplace: Failie, Kent Co. Md.

MOTHER
14. Maiden name: Betty Brook Mitchell
15. Birthplace: Baltimore, Maryland

16. Informant: Mr. Wm. Ed. Loller (father)
Address: Worton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Chester

Location: Chestertown

18. Funeral director: Marion V. Williams

Address: Chestertown, Maryland

19. Dec. 23, 1947 (Date rec'd by registrar) Clara S. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1947, at 7 ~~00~~ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-22 1947, to 12-22 1947 and that I last saw him alive on 12-22-47 19

Immediate cause of death	DURATION
Septicemia?	4 days
Due to: Pneumonia (Type unknown)	
Due to: There were indications deceased died of Waterhouse-Friderichsen syndrome but since autopsy was not done cannot say definitely. Blood cultures not yet reported on.	

Other conditions (Include pregnancy within 3 months of death)

Major findings of operation: Cultures findings negative [12-23-48 also]

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert W Farr M. D. ~~or other~~

Address: Chestertown, Md. Date signed 12-22-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11342

940

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: Park Row

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles R. Pippin

3. (b) Social Security Number: 220-09-1307

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 8, 1878

8. AGE:

Years	Months	Days	If less than one day
69	8	6	..... hrs. ..... min.

9. Birthplace: Chestertown, Maryland (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Barber Shop

FATHER

12. Name: Robert K. Pippin

13. Birthplace: Maryland

MOTHER

14. Maiden name: Annie Tomlinson

15. Birthplace: Maryland

16. Informant: Mrs. Belle Smith (sister)

Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 17, 1947 (month) (day) (year)

Cemetery or crematory: Chester Cemetery

Location: Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Dec 16 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1947, at 10.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1947, to Dec 14 1947 and that I last saw him alive on Dec 13 1947

Immediate cause of death	DURATION
Angina pectoris	sudden
Due to: Coronary sclerosis (Coronary)	
Due to:	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. G. Simpson M. D. or other

Address: Chestertown Date signed: 12-15-47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11343

932

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent Co

City or town: Betterton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Kent

City or town: Betterton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mable B. Rollison

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John B. Rollison

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feb 17 - 1890

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Balt. (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business

FATHER

12. Name: John Brown

13. Birthplace: Balt

MOTHER

14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mr. J. B. Rollison

Address: Betterton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-30-47 (month) (day) (year)

Cemetery or crematory: Judy

Location: Church Hill Md

18. Funeral director: Edgar L. Lane

Address: Church Hill Md

19. 12-30 1947 (Date rec'd by registrar) J. McCauley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1947 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1946 to Dec. 28 1947 and that I last saw h.e.r. alive on Dec. 28 1947

Immediate cause of death: Pulmonary edema

Due to: hypertension cardiovascular disease

Due to: angina

Due to: myocardial insufficiency

Other conditions: myocardial decompensation

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. R. Coppola, M.D. M. D. or other

Address: Chestertown, Maryland Date signed 12-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

462

11344

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Kent & Queen Ann. Hosp.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Kennedyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Kennedyville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: J. Norton Silcox

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Clara G. Silcox
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): November 23 1886

8. AGE:

Years	Months	Days	If less than one day
61	0	22	hrs. min.

9. Birthplace: Kennedyville, Kent Co. Md
(Town, county, and state)
10. Usual occupation: farmer
11. Industry or business: retired

FATHER
12. Name: John Silcox
13. Birthplace: Odessa Delaware

MOTHER
14. Maiden name: Sarah Mure
15. Birthplace: Bellevile Kent Co. Md.

16. Informant: Mrs. Clara G. Silcox (Wife)
Address: Kennedyville - Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 1947 (month) (day) (year)
Cemetery or crematory: Still Pond
Location: Still Pond
18. Funeral director: Marvin V. Williams
Address: Chestertown, Maryland

19. Dec. 18, 1947 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1947 at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Dec. 15 1947 and that I last saw him alive on Dec. 15 1947

Immediate cause of death: Uremia, terminal

	DURATION
Due to: hepatic + renal insufficiency;	
Carcinomatosis, site unknown;	
Due to: probably sigmoid	
Other conditions: anemia; avitaminosis; intestinal obstruction	

(Include pregnancy within 3 months of death)

Major findings of operation: ~~dif~~ Carcinomatosis
Date of op.: Aug 1947
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. R. Coppola, MD
M. D. or other
Address: Chestertown, Md. Date signed: 12-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11345

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Kent St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Kent St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Martha P. Slagle

3. (b) Social Security Number
216-16-7533

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Wm. T. Slagle

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1874

8. AGE: Years	Months	Days	If less than one day
73	9	10	____ hrs. ____ min.

9. Birthplace: Cecil Co. Maryland
(Town, county, and state)

10. Usual occupation: Cannery Worker

11. Industry or business: Vita Foods

FATHER
12. Name: Edward Wamsley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Henretta Davis
15. Birthplace: Maryland

16. Informant: Wm. Slagle (son)

Address: Chestertown, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 6, 1947
(month) (day) (year)

Cemetery or crematory: Chester Cem.

Location: Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Dec. 5 1947 Chas. S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 3 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1947, to Dec 3 1947 and that I last saw him alive on Dec 3 1947

Immediate cause of death	DURATION
Coronary thrombosis	1 2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. Higgins M. D. or other

Address: Chestertown Date signed: 12-4-47

W

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

526 gn

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926 11346

Reg. Dist. No. 204

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown R.D. #2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, Institution, or street address where death occurred: Sandy Bottom - Near St. Paul Church

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown R.D #2
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near - St. Paul Church -
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Samuel C. Willis

3. (b) Social Security Number —

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: (late) Susanna L. Willis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 19 1866

8. AGE: Years: 81 Months: 8 Days: 19 If less than one day ..... hrs. ..... min.

9. Birthplace: Kennedyville Kent Co. Md.
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: farm

FATHER 12. Name: Cambria M. Willis

13. Birthplace: Kent Co. Maryland

MOTHER 14. Maiden name: Sarah Elz. Bramble

15. Birthplace: Kent Co. Maryland.

16. Informant: Mrs. John W. Biggs

Address: Chestertown Md. R.D #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11, 1947 (month) (day) (year)

Cemetery or crematory: Chester

Location: Chestertown, Maryland

18. Funeral director: Marvin V. Williams

Address: Chestertown Maryland

19. Dec 11 1947 (Date rec'd by registrar) F. H. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1947 at 6:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1943 to Dec 8 1947 and that I last saw him alive on Dec 6 1947

Immediate cause of death: Chronic Endo-Myocarditis
Secondary Hypertension
Due to: Chronic Bronchitis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md. Date signed: 12/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11347

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Worton Rural Coleman (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Worton Md Coleman Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.: Worton Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alexander Wilson

3.(b) Social Security Number: 216-18-2463.

4. Sex: M

5. Color or race: C

6.(a) Single, married, widowed, or divorced: Widower.

6.(b) Name of husband or wife: Annie Wilson

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Age unknown

8. AGE: Years: Approx. 78 Months: — Days: If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state): Kent Co. Maryland

10. Usual occupation: Farm work

11. Industry or business: Farm

FATHER 12. Name: John Wilson

13. Birthplace: Kent Co Md.

MOTHER 14. Maiden name: Susan White

15. Birthplace: Kent Co. Md.

16. Informant: Melbur Wilson

Address: Worton Md Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1947. (month) (day) (year)

Cemetery or crematory: Colemans

Location: Colemans Worton Md Rural

18. Funeral director: B.K. Fellows.

Address: Still Cove Md

19. Dec 4 1947 (Date rec'd by registrar) J H Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1947, at 2.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947, to Nov 30 1947 and that I last saw him alive on Nov. 30 1947

Immediate cause of death: Cancer of Prostate — DURATION: 1 yr

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Prostate — Date of op. Nov 1947

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred W Smith M. D. or other

Address: Chestertown Md. Date signed: 12/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

11348

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Same County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Myrtle Venora Wilson

3.(b) Social Security Number 212-03-0956

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February, 21, 1908

8. AGE: Years 39 | Months 9 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Store

FATHER
12. Name: Clarence T. Wilson
13. Birthplace: Delaware

MOTHER
14. Maiden name: Ruth N. Calhoon
15. Birthplace: Delaware

16. Informant: Clarence T. Wilson, Brother
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 11 (month) (day) (year) 1947

Cemetery or crematory: Chester

Location: Chestertown, Md.

18. Funeral director: J. Willis Wells
Address: 415 High St, Chestertown, Md.

19. Dec. 16 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-9 1947, at 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-26 1947 to 12-9 1947 and that I last saw her alive on 12-8 1947

Immediate cause of death	DURATION
Cachexia	1 month
Due to: Visceral carcinomatosis	2 months
Due to: Carcinoma of sigmoid colon	6 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert [illegible] M. D. or other

Address: Chestertown, Md. Date signed: 12-10-1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING